Report of Pre-Summit Meeting Region VI

Wednesday
February 18, 2004

The Rapides Foundation Building
Alexandria, LA

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Introduction

On February 4, 2004, The Rapides Foundation was asked to host the Region VI pre-summit meeting, as a precursor to the statewide Louisiana Healthcare Summit to be held March 3rd and 4th in New Orleans. On Tuesday, February 10, personalized invitations were sent to 160 community members representing broad constituencies. Among the groups invited were public and private healthcare providers, medical educators, employers, regional and local elected officials, healthcare trade associations, including insurers, and advocacy groups representing the developmentally disabled, mentally ill, children and the uninsured. Per instruction from the Office of the Governor, these invitations were meant to reflect individuals and organizations representing or serving DHH Region VI. This includes Avoyelles, Catahoula, Concordia, LaSalle, Grant, Rapides, Vernon, and Winn Parishes. This grouping does **not** include past and present Rapides Foundation Service Area Parishes of Allen, Evangeline and Natchitoches.

The Rapides Foundation

The Rapides Foundation (RF) was founded in 1994 as a result of a joint partnership between Rapides Regional Medical Center and Columbia/HCA (now HCA). Concurrently, a philanthropy was established that has current assets of $200 million and grantmaking of $8-10 million annually. The RF works to improve the health and well-being of Central Louisiana residents through grantmaking and direct operating programs in individual healthcare access and health promotion, K-12 education and community and economic development.

Previous/Current Assessment Work

In 1997, The Rapides Foundation (RF) commissioned the first comprehensive study of healthcare status and behaviors in the region, in association with the Tulane School of Public Health and Tropical Medicine. The study received a great deal of public and media attention as it brought to light a number of unenviable health status issues including: difficulty in accessing healthcare services for the low-income and uninsured; high levels of chronic disease for the community-at-large, and lifestyle choices that lead to poor health outcomes. In 2002, Professional Research Consultants (PRC), a national survey research firm, revisited the study via a random telephone survey of 4,750 households in the region; a compilation of updated secondary data; and the convening of 15 community health panels, with special focus on gathering input from rural residents in the parishes outlying Rapides Parish. The PRC health assessment data is available through The Rapides Foundation web site at www.rapidesfoundation.org.

In the years 2001-03, The Rapides Foundation (RF) commissioned the Health Informatics Center of Acadiana at the University of Louisiana at Lafayette to collect primary and secondary data specific to Healthcare Access Barriers in 11 parishes of Central Louisiana. The study team gathered information from almost 200 households in each parish. One half of these interviews were conducted via random phone survey but, importantly, almost 100 interviews were conducted face-to-face at sites where the

uninsured would likely use community services, such as the waiting area at the public hospital; health units and various retail establishments like Dollar Stores and Wal-Marts. Well over 40% of the respondents indicated some barrier to accessing standard healthcare sites or needs. Detailed information on this study is available from The Rapides Foundation.

Finally, in 2003, the RF commissioned The Lewin Group, a national health policy consulting firm, to develop a report on options for best serving the uninsured in the region. This report, to be finalized in the next 60 days, considers current payment and service patterns in the region and presents a number of options that should be considered for better serving this population. These options will include distinct considerations of the differing issues in providing inpatient and outpatient services to this large group of residents. In addition to the objective data analysis, The Lewin Group has interviewed over 25 provider leaders and will be reconvening these and other community leaders over the next 30 days.

Meeting Format and Participation

The pre-summit meeting was held on February 18 from 5:00 - 8:15 pm in the Kress Theatre at The Rapides Foundation Building in downtown Alexandria. An independent facilitator, Ms. Kristy Nichols, Director of the Bureau of Primary Care and Rural Health, DHH, moderated the meeting. The audience, numbering approximately 210, included residents representing all eight of the parishes included in the directive from the Office of the Governor. An attendance list is attached.

The format of the meeting was as follows:

(1) Introduction of evening's agenda
(2) Presentation of selected health status information by Professional Research Consultants
(3) Presentation of selected healthcare provider information by The Lewin Group
(4) Consideration of six discussion questions in two formats – participants could stay with a general group and provide two minute statements recorded by a transcriptionist. Alternatively, participants could join one of four facilitated discussion groups centered around the following themes:
    1. Special Populations
    2. Chronic Conditions
    3. Physicians, Hospitals and Providers
    4. Access to Care/Public Hospitals

The rest of this document summarizes the public comments. All public comments were transcribed when provided as part of the general group and are attached to this report. Audience members were invited to stay after the conclusion of the meeting to provide any additional comments to convey to the Office of the Governor. They were also invited to submit written comments and documents. Summaries of the facilitated discussion groups are also attached.

Question #1 -What challenges (if any) do the following populations pose in your community?

Uninsured Population

Huey P. Long Medical Center provides the majority of inpatient and outpatient care for the region's uninsured. Cuts over the last five years to the public system have increased wait times for both emergency and clinic care. This has caused some movement of the uninsured to Rapides Regional Medical Center and CHRISTUS St. Frances Cabrini Hospital's Emergency Rooms. Respondents described these patient movements for both patients seeking care for emergent conditions, as well as traumatic events necessitating inpatient admission. The current DSH payment system does not compensate most private providers for these patients, nor is there any physician compensation - creating a disincentive for private providers to provide any level of non-mandated care for these patients. These various payment issues also discourage any continuity of care for the uninsured and do not provide any opportunities for preventive care; particularly for rural residents who may have significant transportation barriers. Some respondents wanted to note, however, that emergency rooms may be the best access point for care for the uninsured.

A number of participants indicated that rural residents were often unaware of affordable healthcare available in their parishes through the three area FQHCs, including dental care.

Little to no service options exist for the uninsured with episodic, mild or some types of long-term mental health and substance abuse issues - particularly those who fall short of the various state criteria for severity of illness.

Medicaid Population

All sessions had serious and lively discussions concerning the policies and practices of the Medicaid program. The summary below refers primarily to comments regarding challenges to care for the Medicaid patient. Other Medicaid related concerns are described under Questions #4 and #5.

Medicaid-eligible patients often have difficulty enrolling in the program because there are few enrollment sites in the region. They may be assigned a Community Care physician that is not located close-by, reinforcing the emergency room as the place to seek primary care. Pregnant women are sometimes delayed in their ability to get a Medicaid card - postponing prenatal care.

Mental health services available to the Medicaid population are extremely limited, particularly psychiatric services for both children and adults. Transportation services are limited and may be poor in quality. Lack of accessible programs for hearing aids, eyeglasses, occupational therapy and similar supports and therapies limits continuity of care and quality of life. Response to requests for certification of Medicaid patients for

home healthcare can be slow and difficult to obtain. Few, if any, dental services exist by private providers.

In general, provider reimbursement is believed to be below the level where an adequate level of care can be maintained. This limits participation in the program and limits Medicaid recipients' choices for care.

Medicare Population

The majority of community challenges for the Medicare population concerned inability to purchase medication for: chronic care disease, medication prescribed in response to an injury or illness, and medication related to specialty treatment for conditions like Alzheimer's Disease.

Other concerns were expressed regarding required co-pays at nursing homes, transportation difficulties, and payment mechanisms that impact whether an individual can get care on an inpatient or outpatient basis. There is also a sense among providers that Medicare patients have very little understanding of what services Medicare will and will not pay for - patients may believe that Medicare provides payment for any type of service the patient or their family wants.

Privately Insured

Some generalized discussion took place about low contract payments to providers, particularly for home health services.

Specific to the Mentally Retarded/Developmentally Disabled population, residents sometimes use their maximum benefits under their private insurance plan. During the transition to Medicaid, there is a loss of coverage, followed by a transition to different physicians and resultant loss of continuity of care.

Question #2 - What are the healthcare needs of the following populations in your community?

Note - There was significantly less discussion on this question than any of the others.

Children

Regionally, LaChip has provided a significant increase in the availability and use of health services for lower-income children. Lack of availability of mental health services are an ongoing concern. Significant dental health issues exist, but access barriers and lack of parent knowledge or motivation limit use of available programs.

There was some discussion concerning regional child and adolescent public health issues like obesity, high asthma rates and teen pregnancy - the region needs programs integrated

into existing infrastructure to respond to these and similar issues, rather than stand-alone limited duration programs.

People ages 65 and older

In addition to the challenges associated with medication (as previously noted), a number of respondent groups noted high levels of obesity among older adults who were their patients, clients, family and friends. Older adults in the region also have transportation challenges to accessing care.

Several group members strongly advocated for an increase in nursing home rates that would allow for better response to the healthcare needs of nursing home residents.

People with Developmental Disabilities

Participants in the Special Populations discussion provided a strong voice to needs of the Developmentally Disabled population, most of which related to the state system of funding and delivery of care, rather than specific healthcare needs. Many of their issues are noted in response to Questions #4, #5 and #6.

Two specific healthcare service issues were identified: (1) The need for earlier identification and intervention for children with possible developmental delays, and (2) Instances where adults must stop working so their income can be reduced to qualify for Medicaid.

People with Mental Illness

There appears to be a shortage of care for many population groups (rural, geriatric, children, dual-diagnosed) on both an outpatient and inpatient basis. Cost of medication is a concern, as is a shortage of easily accessible psychiatric care and consultation.

People with Addictive Disorders

Similar to the comments for those people with mental illness, there are severe shortages of outpatient and inpatient services for this population. One group, Persons with HIV/AIDS, was singled out as in need of currently unavailable specialized services.

Question #3 - What are the strengths of your community's healthcare system?

Region VI has a uniquely strong regional healthcare infrastructure already in place - particularly in comparison to other regions with a large rural geography. Public responses to this question can be divided into three groupings: (1) availability of providers, (2) availability of programs, and (3) community readiness.

Availability of Providers - The region has two very stable regional acute care hospitals (Rapides Regional Medical Center and CHRISTUS St. Frances Cabrini Hospital) based in Alexandria, but is also very fortunate to have a regional public hospital, LSUHSC-Huey P. Long Medical Center and a VA Medical Center – both located in Pineville. Respondents also mentioned strong rural hospitals in Allen, Avoyelles, LaSalle and Vernon Parishes. The hospitals have been aggressive physician recruiters and are willing to invest in bringing both primary and specialty care providers to the area. Some participants noted access to some physicians who do accept Medicaid as a regional strength.

The presence of both Tulane and LSU Residency Programs is a key infrastructure element in the area. Many area physicians have located here on a permanent basis as a result of the long-standing relationship between Huey P. Long Medical Center and Tulane University. Unfortunately, due to cost, patient volume and accreditation requirements, some of those Tulane/Huey P. Long residencies have been eliminated in recent years. The LSU Family Practice Residency, affiliated with LSUHSC - Shreveport, started in 1995 with a grant by The Rapides Foundation, is based in Alexandria, and is an important program for developing primary care physicians for the region. The program is financially supported by Rapides Regional Medical Center.

Members of the Special Populations discussion group noted the availability of ICF/MR facilities, for those who want them, as an area strength.

Availability of Programs - Two Rapides Foundation initiated programs, Cenla Medication Access Program (CMAP) and the Parish Nurse Program were mentioned numerous times. CMAP is a regional medication access and education program with 9000 clients who receive their chronic care medication through this effort. The Parish Nurse Program, begun in 2003, is a wellness based program utilizing the skills of volunteer congregational nurses in over 20 churches, with formal goals to expand and engage broad segments of the regional faith community over the next couple of years.

CHRISTUS St. Frances Cabrini Hospital has been a leader within the state in the development of School-Based Health Centers - in rural as well as urban communities in the region. These Centers are proving successful in keeping children in school, and providing them with a solid foundation of preventive health practices and programs. A recently opened Center in Allen Parish, with support from Oakdale Hospital and The Rapides Foundation, is piloting a variety of enhanced wellness strategies targeting adolescents already burdened by obesity, diabetes and other lifelong health concerns.

Huey P. Long Medical Center has been a leader within the LSU-HCSD system in the development and establishment of disease management programs targeting diabetes, asthma, HIV and congestive heart failure. Also mentioned was a unique DHH program being hosted by Huey P. Long, that pairs low-income mothers and nurse home visitors, in collaboration with private practice OB/GYNs. This is Louisiana's largest scale implementation of the nationally recognized Olds model focused on reducing the area's infant mortality rate, currently the 3rd highest in the state.

Community Readiness - Several respondents mentioned a unique community dynamic where public and private providers have expressed a strong willingness to work together to develop enhanced services and service integration for all residents. This may have not been the case previously, but is thought to be true now.

Question #4 - Identify any important gaps in your community's healthcare system. How would you (pre-summit respondents) address these gaps?

Note - Much of the initial response to this question became incorporated into discussions/Questions #5 and #6.

Alzheimer's Disease - Gaps in diagnosis, medication use/ knowledge and referral networks.

End-of-Life Care - Extreme underutilization of hospice services in appropriate and timely manner.

Healthcare Workforce - Dependence on educational institutions based outside the region for training of most allied health professionals. Shrinking population of nursing students under age 30 and dramatically lower numbers of local nursing graduates compared to 10 years ago.

Mental Health - Very limited acute care and residential services.

Prevention/Early Identification - Very few effective programs that try and develop good health habits, rather than focusing exclusively on the treatment of illness. Similarly, very few effective screening programs exist prior to residents developing symptoms of illness.

Provider Access - Availability of primary care services for the Medicaid and uninsured populations is spotty, depending upon geography and provider practice patterns. Regional access to many subspecialties for these populations is non-existent. No governmental insurance coverage available for more than 95% of adults ages 20-64.

Resource and Referral - An easily understood single point of entry and/or a comprehensive local model of resource and referral for health and related services.

Trauma Care Network - A standard and well articulated Best Practices model does not exist for providers to implement local trauma services and to access specialty trauma services in Shreveport and New Orleans.

Question #5 - Describe changes that could be implemented to improve the healthcare in your community with specific consideration given to access, quality and cost (to the state and patient) of services?

Uninsured

- Have DSH dollars follow the patient, rather then be institution-based as currently implemented.
- Increase funding of DSH pool to financially stabilize Huey P. Long Medical Center.

Medicaid

- Improve provider reimbursement rates to encourage greater participation and patient choice.
- Consider a patient co-pay to promote patient investment in their own care and to raise revenue.
- Involve pharmacists more deeply in the reconfiguration of the Medicaid formulary to help prioritize medications based upon usage patterns and cost to the state. Eliminate physician override for brand name drugs - mandate generic.
- Actively engage providers in promoting compliance and appropriate utilization of Medicaid services.
- Stop or decrease required Medicaid visits for nursing home and developmentally disabled populations.
- Keep Medicaid dollars within the sectors that impose a provider tax.
- Administer Medicaid like private insurance – approve services through providers with the lowest costs (PPO concept).
- Lift the Medicaid reimbursement ceiling for Huey P. Long Medical Center to allow for greater financial stability.

People with Mental Illness

- Recognize that current state system will primarily serve forensic patients in future. With private providers, develop a new system.

People with Developmental Disabilities

- Promote and support patient and family choice. Develop more state-supported residential choices. Support closer monitoring of current state-funded residential options.

Healthcare Workforce

- Stabilize and increase physician training programs in the area, including pursuit of joint LSU and Tulane physician training.
- Promote and allow for greater utilization of mid-level practitioners like Nurse Practitioners and Physician Assistants to increase access and decrease cost.
- Better incentive programs to retain healthcare professionals.

Systems

- Blend state and federal systems like LSU and the VA to increase access, decrease duplication and, long-term, reduce cost.
- Get greater benefit from resources, experience and technical knowledge of LSU system.
- DHH should create a Futures Task Force aimed at providing ongoing technical information for long-range healthcare planning in areas such as diagnostics, treatment, technology, pharmaceuticals, daily living supports. This could be modeled after a similar effort by CHRISTUS Healthcare.
- Develop systems of collaboration among multiple providers for the same individual (e.g. OPH/OAD/LSU-HCSD).
- Mandate that all state-funded services be truly regional, rather than being regional in concept only.

Coverage

- Implement a HIFA waiver model to pilot successful coverage strategies that could be used statewide.
- Provide tax incentives to small businesses who offer affordable health insurance coverage.
- Provide tax incentives to purchase long- term care insurance.

Question #6 - How should state healthcare spending be prioritized to support your community in meeting its needs?

Patients

- Allow residents ability to access greater choice of providers for all services - let reimbursement follow the patient.
- Allow some alternative services for Special Populations on long waiver lists.

Providers

- Adequate reimbursement for all providers to enhance access to care.

Systems

- Ensure that all federally secured health dollars are used for their intended purpose.
- Develop formal integrated delivery systems for care of Medicaid and uninsured.
- Develop and maintain long-term state focus on improving national health status rankings.
- Develop and support integrated trauma network using federal funds.

Facilities

- The physical plant of Huey P. Long Medical Center must be addressed as soon as possible.

Potential Funding Sources

- Consensus that state has been slow and ineffective in pursuing competitive federal funding in areas such as mental health, disease management, homeless healthcare and other opportunities.
- Create state matching incentives for local jurisdictions to pursue local financial support for healthcare delivery.
- Health Insurance Financing Act (HIFA) Waiver
- Commit to securing all available federal matching dollars.
- Active and sincere cultivation of national foundation interests for issues like health disparities, chronic disease prevention, systemic reform, access for all.
- Provider tax
- Enhanced and targeted sin tax revenue from alcohol, tobacco, gambling.

Summary

Community input gathered at the February 18 meeting and summarized in the previous pages is consistent with the community health assessment and planning efforts that The Rapides Foundation has facilitated over the past seven years. Much more detailed information can be found on the Foundation's Web site and in the Tulane, Professional Research Consultants and UL - Lafayette reports that are described on pages three and four.

While a wide variety of excellent healthcare services are available in the Alexandria/Pineville urban center of the region, outpatient services for the Medicaid and uninsured populations are provided primarily by a public hospital (Huey P. Long Medical Center). Acute care inpatient services are increasingly being handled by both local private hospitals as well as LSUHSC-Shreveport, as Huey P. Long residency programs and related services have been downsized. Similar downsizing has occurred in the public sector for services to the mentally ill and those with substance abuse problems. Wait times for all these publicly funded services are long. While not directly correlated with access to healthcare services, the health status of the Medicaid and uninsured population in the region is significantly worse than the statewide averages.

There is a belief that a strong will exists among both local public and private providers to develop a more effective healthcare system for the uninsured and Medicaid populations which comprise almost 50% of the working age adults in some of the region's parishes. **The relatively small population of the region, coupled with the wide range of existing quality healthcare service providers in both the urban and rural areas, makes Region VI an ideal area for the development of an effective continuum of care model.** This model could (and should) provide better prevention-oriented primary care, enhanced specialty services and less travel for those who, for whatever reasons, have difficulty in getting the healthcare services they need.

The critical questions that have been raised:

- Can the current dollars received in the region for Medicaid and uninsured patients be, at a minimum, maintained?

- Can these funds be used to follow the patient rather than be provider-based?
- Understanding that the physical plant of Huey P. Long Medical Center has a lifespan of less than five years, what is the "right size" for a new Huey P. Long; who will pay for it; what services will be offered; who will provide the medical staffing and would the new facility have to substantially increase its patient base with Medicare and commercial insured patients?
- Can urban and rural hospitals and community-based primary care providers contract with DHH for services to the uninsured for acceptable rates?
- How can appropriate healthcare use be stimulated and supported for the 25% (est.) of uninsured residents that appear to have dropped out of the system?
- Using existing unused hospital physical space, can a hospital within a hospital concept be developed that allows disproportionate share funds to be collected and maintained without a federal waiver?
- Can a system be developed with LSUHSC-Shreveport that greatly expands the services currently available for Medicaid and uninsured patients?
- Publicly funded mental health and addiction services serve a very small proportion of those in need. What plan can be developed for increased and effective private sector participation?
- How can state dollars for the developmentally disabled be best used to move from state-operated programs with limited options to private sector programs with a wider range of options?

As the appointed host of the Region VI pre-summit meeting, The Rapides Foundation would like to strongly assert the need to continue the work already begun in collaboration with the DHH-led effort under Jen Steele's leadership.

The Lewin study, described on page four of this document, will be an important tool that provides a commonly understood set of data and assumptions on services and funding for the safety net population. The Rapides Foundation intends to aggressively press ahead with this work, in close collaboration with local stakeholders, and reach agreement on realistic proposals for enhancement within the next 90 - 120 days.